FIRST STEPS COST PARTICIPATION EXPENSES WORKSHEET

State Form 51359 (R / 4-06) / BCD 0093
Division of Disability and Rehabilitative Services

First Steps

Effective May 01, 2006

This form is to be reviewed with the family during the intake process by the intake coordinator and is completed upon the family's request. The form is also reviewed annually, coinciding with the IFSP. Once requested by the family, the SC is to review and complete this form within 30 days.

Name of child	Date of birth (*month, day, year*)	First Steps ID
Name of parent(s) / guardian(s)		

Medical Expenses: Out-of-pocket medical/healthcare expenses from the **previous 12 months** in which the family has not or will not be reimbursed.

Personal Care Needs Expenses: Out-of-pocket expenses from **the previous 12 months** that are related to the health or medical needs, in which the family has not, nor will not be reimbursed.

Expenses must be directly related to the health or medical condition of a family member. Expenses must be out-of-pocket expenses from the previous 12 months and those for which the family will not be reimbursed. Verification of expenses must be attached. **Document the expense and check the frequency it occurred. Expenses may be considered initially and annually.**

Health insurance premiums	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Annually
Insurance co-payments	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Annually
Dental and Vision expenses	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Annually
Hospital expenses	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Annually
Prescriptions	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Annually
Nutritional supplements as ordered by a physician	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Annually
Durable medical equipment / assistive technology / adaptations	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Annually
Specialized clothing as required per medical condition	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Annually
Specialized respite care or child care above that of typical costs	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Annually
Medical transportation costs	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Annually
Other related medical costs (*attach list*)	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Annually
Other personal care needs expenses relating to a medical condition (*attach list*)	$_____	☐ Weekly	☐ Bi-Weekly	☐ Monthly	☐ Annually
TOTAL EXPENSES	**$**				

I have supplied accurate information and agree with the calculations above:	
Signature of parent / guardian	Date (*month, day, year*)
I have reviewed all documentation and agree with the calculations above:	
Signature of service coordinator	Date (*month, day, year*)

DISTRIBUTION: Original - SPOE, Copy - Service Coordinator and family